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WEIGHING TWELVE POUNDS,

SUCCESSFULLY REMOVED BY

## LAPAROTOMY.

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GENIA (M.)





INTRA-PERITONEAL MYO-FIBROMA OF THE  
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The most experienced surgeon is most conservative in his diagnosis of abdominal tumors, as he has only too often had an opportunity to change his diagnosis after he has opened the abdomen. It cannot be said that the additions to our diagnostic resources in the recognition and classification of tumors in the peritoneal cavity have kept pace with the perfection of the technique of abdominal operations during the last twenty years. Certainly a correct diagnosis in obscure cases of abdominal tumors is greatly to be desired, but is often not attainable with our present means of diagnosis.

In view of the difficulties which so frequently surround a positive diagnosis, it has been advised not to rely too much upon ordinary methods of examination, but to subject doubtful cases at once to an exploratory laparotomy, and, if required, follow it with the necessary ~~medical~~ treatment. Although the opening of the abdomen, under strict antiseptic precautions for diagnostic purposes, is not attended by much risk to life, no conscientious surgeon will make light of this procedure, and will not resort to it until he has satisfied himself after

a most painstaking and thorough examination, that a diagnosis cannot be made without it, and that the conditions within the abdomen in all probability will require surgical treatment. The following case is reported, for the purpose of showing how difficult it is in some cases to determine, beforehand, the primary location and starting point of solid intra-pelvic tumors, and at the same time to point out the impossibility, by our present means of diagnosis, to differentiate between intra-peritoneal myo-fibroma of the rectum projecting into the peritoneal cavity, and solid tumors of the ovary, broad ligament, and pedunculated myo-fibromata of the uterus. I have been unable to find a similar case in the literature, although a careful search has been made dating back for at least twenty years.

The patient was a married lady, æt. 45, the mother of seven children. A pelvic tumor the size of a walnut, was accidentally discovered by Dr. Philler, of Waukesha, her family physician, while attending her for miscarriage, about three years ago. The tumor at that time was felt between the uterus and rectum and appeared to be firmly attached. For two years the tumor caused no inconvenience, and the patient remained in her usual health, when the abdomen gradually commenced to enlarge, and the patient to complain of some pelvic distress. Six months later her general health began to decline, want of appetite and considerable loss of flesh. The patient never suffered from constipation or any other symptom pointing to the rectum as the primary seat of the tumor. Menstruation normal, both as to time and quantity. The patient was admitted into the Milwaukee Hospital, April 20, 1890. At this time she was anæmic, considerably emaciated and the abdomen greatly distended by fluid, and both lower extremities and the hips œdematous. A careful examina-

tion of the heart and liver revealed nothing that would account for the ascites, and with the exception of being scanty, the urine was found normal. The supposition was that the ascites was caused either by malignant disease of one of the abdominal organs or by tubercular peritonitis. A pailfull of a clear serous fluid was removed by tapping. As the abdomen was being emptied a large solid tumor became apparent, occupying the left and lower portion of the abdomen. Bi-manual examination of the uterus revealed this organ of normal size, but displaced to the right and pushed or drawn upward by the solid tumor. It could be clearly established that no direct connection or adhesion existed between the uterus and the tumor. The right ovary could be detected in its proper location and of normal size. The left ovary could not be discovered. It was now evident that the tumor was the same that had been discovered two years before, and that in all probability the ascites was caused by it. The tumor was quite movable and could be pushed from the vagina in an upward direction for several inches, and could also be rotated around its axis, but when released would always return into the same position. The attached portion appeared to be low down in the pelvis. A probable diagnosis of a solid tumor of the ovary or broad ligament on the left side was now made and a radical operation advised. Some sixteen years ago I removed a solid tumor of the left ovary, almost under similar circumstances, and the patient remains in perfect health to-day.

Laparotomy was performed April 24, 1890. Although only four days had intervened between the time of the tapping and the operation, the abdomen had again become distended by a large quantity of the same kind of fluid. The operation was performed under strict antiseptic precautions. An incision was made half way



between the umbilicus and pubes large enough to introduce the hand. After all of the serum had escaped, the relation of the tumor to the uterus and its adnexa was carefully examined. The uterus was found normal in size, but displaced upward and to the right by the tumor. The right ovary, tube, and broad ligament could be readily identified, were normal in size and structure, and had no connection whatever with the tumor. The tumor was hard to the touch, and evidently covered with peritoneum. No adhesions. In searching for its attachment, I found that its pelvic portions became more and more contracted, until at the deepest portions of the pelvis near the middle line, the attached part was somewhat flattened in a vertical direction, and about three times the diameter of the first joint of the thumb. On account of the inaccessibility of the attached portion, should hæmorrhage be encountered, I did not make an attempt to remove the tumor by enucleation. As it was impossible to ligate the base of the tumor without lifting it partly out of the pelvis, this was done by an assistant. It was intended to tie the contracted, attached part in three sections; the upper and lower part by transfixion; the central portion by throwing the ligature around it after cutting the tied sections. As soon as the transfixed portions had been cut and the last ligature was to be applied, the tumor was torn out of its bed by the traction made by the assistant. Immediately upon the removal of the tumor, a small quantity of fluid fæces escaped into the pelvis, which was at once carefully removed with a sponge, and the surface compressed to prevent the extravasation, until I could determine what had happened.

Upon examination of the torn surface of the tumor, I found attached to it a strip of mucous membrane, somewhat oblong in shape, about half an inch in length and

one-third of an inch in width. The escape of fæces left no doubt that some part of the large intestine had been injured, but some doubt existed as to the exact location of the wound. Rectal insufflation of air demonstrated, that the opening existed at the floor of the pelvis, at a point over the middle of the rectum, where the peritoneum is reflected forward over the bladder. A large soft rubber tube was now inserted into the rectum as far as the sigmoid flexure of the colon, and over this, after careful disinfection of the parts, which had been contaminated with fæces, the opening in the rectum was closed with a number of Lembert sutures. This part of the operation was exceedingly difficult and somewhat unsatisfactory, on account of the deep location of the visceral wound. After another careful toilette of the pelvic cavity, a large Keith's glass drain, surrounded by several layers of iodoform gauze, was inserted in such a manner that its distal end corresponded exactly with the sutured rectal wound. The abdominal incision, which extended from the pubes to the umbilicus, was closed in the usual manner, except at the lower angle, where enough space was left open for the capillary and glass drains. The operation was necessarily a protracted one, lasting nearly two hours, and towards the latter part of it the pulse became very feeble and rapid, the patient at the same time manifesting other symptoms of shock; whisky had to be administered subcutaneously.

The patient rallied well from the immediate effects of the operation. The bladder was emptied by the use of the catheter, and small doses of opium were given to procure rest for the rectal wound. During the first forty-eight hours nothing was given by the stomach but brandy in water and beef tea. Very little fluid escaped through the drainage tube, but this was allowed

to remain for the purpose of guarding against fæcal extravasation, should the rectal wound fail to heal by primary intention. A laxative was administered on the third day, and after the bowels had moved freely, the glass drain was removed and a small quantity of fluid fæces escaped. The tubular wound was gently washed out by irrigation with a solution of boracic acid and the drain re-inserted. The external wound healed without suppuration, and all of the sutures were removed at the end of the first week. Six days after the operation the glass tube was removed, and drainage secured by the insertion down to the rectal wound of strips of iodoform gauze. The fæcal fistula closed completely and permanently two weeks after the operation; after which the drainage opening closed rapidly by granulation and cicatrization. Ascites did not reappear after the operation and the patient is now, nearly a year after the operation, in excellent health.

*Description of tumor.*—The tumor weighs twelve pounds. It is somewhat irregular in outline but on the whole it is nearly globular. It is covered by peritoneum, except at the base, where it was detached from the rectum. At the margins of the attached surface it is easy to trace the tumor between the mucous membrane and the peritoneal coat of the anterior rectal wall. The tumor is very dense throughout, and the cut surface presents the trabeculated structure with multiple foci of growth, so characteristic of myo-fibroma. Under the microscope it can be seen that the fibrous tissue predominates, the fibres being arranged in concentric layers and wavy bundles traversing the tumor in different directions. The muscular fibers, with their elongated large nuclei are arranged in bundles. The tumor tissue is scantily supplied with blood-vessels. The manner of attachment of the tumor as well as its microscopical



structure leave no doubt that it is a myo-fibroma, which started in the anterior rectal wall, probably somewhat nearer the peritoneal than the mucous coat.

*Remarks.*—That an intra peritoneal myo-fibroma of the rectum must be an exceedingly rare affection is evident from the fact that I have been unable to find a similar case in literature. A friend of mine who related this case to Säng<sup>er</sup>, of Leip<sup>zig</sup>, informed me, that the latter had observed a somewhat similar case, but to my knowledge it has never been published; myo-fibroma of the rectum projecting into the lumen of the bowel as a polypoid growth, which if not common, is at least occasionally met with. Quite a number of operations for this affection could be collected. In such cases the primary starting point of the tumor must be near the mucous membrane, which is pushed before it and becomes the covering of the polypus. If the primary matrix of the tumor is located nearer the serous coat, the tumor projects in the direction offering the least resistance, and becomes an intra-peritoneal growth, constriction and pedunculation taking place at the attached portion as the tumor enlarges within the peritoneal cavity. It might be claimed that the tumor was primarily a myo-fibroma of the uterus, becoming later attached to the rectum, and isolated from the uterus by progressive atrophy of the pedicle. Such an explanation is untenable in this case, because at the margin of the attached portion it is easy to trace the tumor substance between the peritoneal and mucous coat, at the same time the surface of the uterus on the corresponding side was found intact and perfectly smooth. In another case, a woman, æt. 41, I removed a myo-fibroma of the anterior rectal wall, the size of a walnut, through an incision of the posterior vaginal wall. This tumor reached down to the mucous membrane of the rectum,

but projected toward the vagina; and if it had been located about two inches higher up, it would have gradually developed into an intra-peritoneal tumor. Even with the light gained from this case, I know of no means to distinguish an intra-peritoneal myo fibroma of the rectum from a solid tumor of the ovary, tube, broad ligament or a pedunculated tumor of the uterus. Manual exploration of the rectum might impart valuable diagnostic information, but it is doubtful if it would lead to positive conclusions. The ascites must have developed in consequence of the mechanical irritation caused by the presence of the tumor in the peritoneal cavity. If, upon opening the abdominal cavity, manual exploration would decide the true nature of the tumor, it would be better, in a similar case, to remove it by enucleation, than to attempt ligation of its base before its removal by excision.

The course, pursued in the management of the visceral wound has served an excellent purpose in preventing extravasation of fæces into the peritoneal cavity not only in this case, but also in one of my cases of gunshot wounds of the abdomen treated by abdominal section. In that case the lowest (thirteenth) perforation was found in exactly the same location. The same precautions were employed, a temporary fæcal fistula formed, but closed at the end of two weeks and the patient made a satisfactory recovery.

A wound in this part of the rectum cannot be securely closed by suturing, and necessitates ample provision for drainage, to prevent subsequently fæcal extravasation, peritonitis and death should the visceral wound not heal promptly. A combination, of capillary and tubular drainage is best calculated to guard against such disastrous consequences from imperfect suturing of the rectal wound.





